National Indian Health Board

Submitted via email

January 12, 2020

Anne Marie Costello
Acting Deputy Administrator & Director
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Extension of the Four Walls Grace Period

Dear Administrator Costello:

On behalf of the National Indian Health Board (NIHB),[1] I write to you regarding the upcoming expiration of the Medicaid clinic "four walls" enforcement grace period on January 31, 2021. As you know, this grace period was initially implemented to allow states and Tribal health care systems to respond to the determination that the Medicaid "clinic" benefit did not apply for services furnished outside of the clinic facility. However, neither the states or Tribal providers have been able to adequately respond to this and take the steps necessary to remedy the issue. This grace period was granted before the on-set of the COVID-19 pandemic, which required a significant diversion of resources. We believe that extending the grace period an additional year, until January 30, 2022, is necessary to allow Tribal providers to take the steps necessary to remedy the issue. It is important that the states and Tribes have adequate time to respond; this time was lost because of the pandemic.

Trust Responsibility

The United States owes a special duty of care to Tribal Nations, which animates and shapes every aspect of the federal government's trust responsibility to Tribes. Rooted in treaties and authorized by the United States Constitution, the federal government's unique responsibilities to Tribal Nations have been repeatedly re-affirmed by the Supreme Court, legislation, executive orders and regulations.[2] In 1977, the Senate report of the American Indian Policy Review Commission stated

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[1] Established in 1972, the National Indian Health Board (NIHB) is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives (AI/ANs). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA),or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

[2] The Court has consistently held that the federal government has a trust responsibility to Tribes, which has formed the foundation for federal/Tribal relations. *See* Seminole Nation v. United States, 316 U.S. 286 (1942), United States v. Mitchell, 463 U.S. 206, 225 (1983), and United States v. Navajo Nation, 537 U.S. 488 (2003).

that, "[t]he purpose behind the trust doctrine is and always has been to ensure the survival and welfare of Indian tribes and people." This trust responsibility is highlighted recently in the Department of Health and Human Services (HHS) Strategic Plan FY 2018–2022:

> Importantly, the Federal Government has a unique legal and political government to-government relationship with Tribal governments and a special obligation to provide services for American Indians and Alaska Natives based on these individuals' relationship to Tribal governments.[3]

The trust responsibility establishes a clear relationship between the Tribes and the federal government.[4] The Constitution's Indian Commerce clause, Treaty Clause and Supremacy clause, among others provide the legal authority and foundation for distinct health policy and regulatory decision making by the United States when carrying out its unique trust responsibility to provide for the health and welfare of AI/ANs and support for the Indian health system that provides their care.

An Extension is Needed

As you know, to mitigate the impact of its determination that the Medicaid "clinic" benefit does not apply to services furnished outside the clinic facility, and that Tribal providers therefore may not be paid the clinic rate for such services, CMS is allowing States to adopt State Plan Amendments (SPAs) to reimburse Tribally-operated FQHCs at the clinic rate. In order to allow sufficient time for states and Tribes to "make [any required] legislative or regulatory policy changes, provide public notice, define services, make system changes, and potentially make programmatic and staffing changes" – CMS announced that it will not review claims for compliance with the four-walls restriction before January 30, 2021.[5] Given the pandemic, however, there has not been sufficient time or resources for Tribal health and policy staff to effectively engage with the states on this. More time is needed to make those changes, and the enforcement grace period should be extended accordingly.

During this COVID-19 public health emergency, State Medicaid agencies scrambled to implement system and state regulation changes related to relief granted through 1135 and 1115 waivers and 1915k amendments, and to deal with the dramatic increase in Medicaid enrollment by individuals who have lost their income due to COVID-19 business closures and "shelter-in-place" orders. The agencies' plates are already overflowing, and those that have not already implemented a Tribal FQHC SPA simply do not have the time, resources, or personnel to do so at this time or in the immediate future. Nor is this the time – when States are seeking emergency permission to cover

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[3] Introduction, "Cross-Agency Collaborations", https://www.hhs.gov/about/strategic-plan/introduction/index.html

[4] In Worcester v. Georgia, 31 U.S. 515 (1832), the Supreme Court explicitly outlined that the relationship between the federal government and the Tribes is a relationship between sovereign nations and that the states are essentially third party actors.

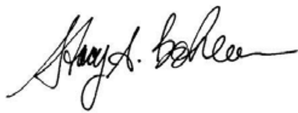
[5] See SHO #16-002, Federal Funding for Services "Received through' an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians and Alaska Natives, https://www.medicaid.gov/federalpolicy-guidance/downloads/SHO022616.pdf; January 18, 2017 "Frequently-Asked Questions (FAQs)" regarding the same, Answer 13, https://www.medicaid.gov/federal-policyguidance/downloads/faq11817.pdf

services furnished in non-traditional settings in response to the COVID-19 – to require Tribal programs to phase out their off-site services or to divert attention from the urgent matters at hand.

Conclusion

NIHB and its partners (including the TTAG) have contacted CMS on multiple occasions regarding this issue, but no response has been given to these requests. Given the lack of time and resources that could be dedicated to addressing this issue, **the grace period must be extended**. Not only is the grace period expiration less than a month away but we are currently dealing with a pandemic that continues to set new records of infection on a daily basis. For the past ten months, our health systems and the states have been grappling and trying to control COVID-19. The Indian health system needs time to take the necessary steps to ensure that we are in compliance with CMS's requirements. **We reiterate our request for a one-year extension until January 31, 2022**. Thank you in advance for your consideration.

Sincerely,



Stacy A. Bohlen
CEO
National Indian Health Board

CC: Kitty Marx, Director, CMS Division of Tribal Affairs